

Minimum Data Set (MDS) for Home Care

1

Score for Behavior/Function over past 7 days

Client Name _____ Date _____

Medical Assistance Number _____ Agency _____

Agency Provider Number(s) _____ RN Signature _____

Section B: Cognitive Patterns

- | | | |
|---|---|----------------------|
| 1. Memory | Short Term Memory appears OK-Seems to recall after 5 minutes
<i>0-Memory OK 1-Memory Problem</i> | <input type="text"/> |
| 2. Cognitive Skills
For Daily Decision
Making | How well client made decisions about organizing the day (e.g. when to get up or have meals, which clothes to wear)
<i>0 Independent-decisions consistently reasonable</i>
<i>1 Modified Independence-some difficulty in new situations</i>
<i>2. Moderately Impaired-decisions poor, cues/supervision needed</i>
<i>3. Severely Impaired-never/rarely makes decisions</i> | <input type="text"/> |
| 3. Indicators of
Delirium | a. Sudden or new onset/change in mental function (including ability to pay attention, awareness of surroundings, coherentness.
<i>0 No 1 Yes</i> | <input type="text"/> |
| | b. In the last 90 days client has become disoriented or agitated such that his/her safety is endangered or client requires protection by others.
<i>0 No 1 Yes</i> | <input type="text"/> |

TOTAL COGNITIVE (B1, 2, and 3) _____

Section E: Mood and Behavior Patterns

- | | | |
|---|---|--|
| 1. Indicators of depression, anxiety, sad mood | <i>Indicators observed in last 30 days regardless of cause</i>
<i>0 Indicator not exhibited in last 30 days</i>
<i>1 Indicator exhibited up to 5 times each week</i>
<i>2. Indicator of this type exhibited daily (6 or more times weekly)</i> | |
| a. A feeling of sadness or being depressed, that life is not worth living, that nothing matters, that he/she is of no use to anyone or would rather be dead | <input type="text"/> | e. Repetitive, anxious complaints/concerns-e.g. persistently seeks attention/reassurance regarding schedules, meals, relationships |
| b. Persistent anger with self or others-e.g. easily annoyed, anger at care received | <input type="text"/> | f. Sad, pained, worried facial expressions-e.g. furrowed brow |
| c. Expressions of what seem to be unrealistic fears (of being abandoned, etc) | <input type="text"/> | g. Recurrent crying/tearfulness |
| d. Repetitive health complaints-e.g. obsessive concern w/ body functions, health | <input type="text"/> | h. Withdrawal from activities of interest |
| | | i. Reduced social interaction |

TOTAL MOOD (E1, a-i) _____

Behavior Patterns

- | | | |
|--|--|---|
| 2. Behavioral Symptoms | <i>Exhibited in the past seven days</i>
<i>0 Did not occur in past seven days</i>
<i>1 Occurred, easily altered</i>
<i>2 Occurred, not easily altered</i> | |
| a. Wandering (moved with no rational purpose) | <input type="text"/> | b. Verbally Abusive Behavior (threatened, or cursed at others) |
| c. Physically Abusive Behavior (to self or others) | <input type="text"/> | d. Socially Inappropriate/Disruptive Behavior (smears, throws body feces, screams, disrobing in public) |
| e. Aggressive Resistance of Care (Threw meds, pushed caregiver, etc) | <input type="text"/> | |
| 3. Changes in Behavior | Behavioral symptoms have become worse over past 30 days
<i>0 No 1 Yes</i> | <input type="text"/> |

TOTAL BEHAVIOR (E2, 3) _____

Section H Physical Functioning**1. Instrumental Activities of Daily Living (IADLs)-Code for functioning in everyday activities in the home**IADL Self-Performance Code*0 Independent-did on own**1 Some Help-Help some of the time**2 Full Help-Needs some help all the time**3 By Others-Always performed by others**4 Activity did not occur*IADL Difficulty Code*0 No Difficulty**1 Some Difficulty (very slow, fatigues, or some help)**2 Great Difficulty (Little or no participation is possible)*

		Performance	Difficulty
a. Meal Preparation	Planning, cooking and set-up	<input type="text"/>	<input type="text"/>
b. Ordinary Housework	Dusting, making bed, laundry, tidying	<input type="text"/>	<input type="text"/>
c. Managing Finances	Pay bills, balance checkbook	<input type="text"/>	<input type="text"/>
d. Managing Medications	Remembering, correct doses, ointments, injections opening containers	<input type="text"/>	<input type="text"/>
e. Phone Use	How made or received, finding numbers	<input type="text"/>	<input type="text"/>
f. Shopping	Food, household goods	<input type="text"/>	<input type="text"/>
g. Transportation	Medical and social events	<input type="text"/>	<input type="text"/>

TOTAL IADL (H1, a-g) _____**2. Activities of Daily Living (ADLs) (Consider all instances over past seven days)***0 Independent - No help or oversight, OR help/oversight provided only 1 or 2 times over past week**1 Supervision – Oversight or cueing provided 3 or more times, possible physical assistance less than three times**2 Limited Assistance – Client highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times**3 Extensive Assistance – Client participated, but weight bearing support OR full assistance given three or more times**4 Total Dependence – Full performance of activity by another over entire seven days**5 Activity did not occur over entire seven days regardless of ability*

a. Mobility in Bed	Moving to and from lying position, turning, and positioning body in bed	<input type="text"/>
b. Transfer	To and between surfaces-bed, chair, standing position (exclude bathroom transfers)	<input type="text"/>
c. Locomotion in Home	If in wheelchair, self-sufficiency once in chair	<input type="text"/>
d. Dressing	Includes laying out clothes, retrieving from closet, putting on and taking off	<input type="text"/>
e. Eating	Include taking in food by any method including tube-feeding	<input type="text"/>
f. Toileting	Include using toilet, commode, bedpan, urinal, catheter, transfers, cleaning self and managing clothing	<input type="text"/>
g. Personal Hygiene	Combing hair, brushing teeth, washing face and hands, shaving	<input type="text"/>
3. Bathing	Include shower, sponge bath, tub bath	<input type="text"/>
4. Locomotion	<i>0 No assistive device</i> <i>1 Cane</i> <i>2 Walker/Crutch</i> <i>3 Scooter</i> <i>4. Wheelchair</i> <i>5. Activity does not occur</i>	<input type="text"/>
a. Indoor Locomotion		<input type="text"/>
b. Outdoor Locomotion		<input type="text"/>

TOTAL ADLS (H2,3,4) _____

FAX completed forms to: ATTENTION: EDS Prior Authorization Department at (401) 941-7712
Or mail to : EDS
 PO BOX 2006

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3

Warwick RI 02887-2006

ATTENTION: EDS Prior Authorization Department